culties of the operation were very different, and the percentage of deaths differed widely as well. He agreed with Sir Spencer Wells that this operation was admissible in certain cases of deformity of the pelvis and in ovarian dysmenorrhœa. He was equally in accord with Wells that it should not be done, as a rule, in cases of madness or so-called menstrual epilepsy. Nor should it be performed on an insane person unless its nature were fully explained to a sane relative.

He pointed out, in conclusion, that whilst such operations should always be preceded by a consultation, that a consultation became a mere farce if one or more of the consultants had made up his mind before hand that all such operations were inadmissible.—*Brit. Med. Jour.*, 1886, Vol. ii, p. 852.

SYPHILIS.

I. Etiology of Gonorrhœal Arthritis. SMIRNOFF. This Russian observer, by examination of the fluid drawn off from a knee-joint of a patient suffering from gonorrhœal (or as it is better termed urethral) arthritis, was able to confirm the results of a few previous writers—that gonococci are present freely in the affected joints. It is interesting to note that lately, Dr. Mantle, of Newcastle, has brought forward considerable evidence in favor of regarding acute rheumatism as depending on a microbic origin.

There are certain differences between urethral and rheumatic joint affections—in particular, the obstinate resistance to treatment which the former present as a rule, but their points of resemblance and the fact that a large number of the urethral cases have previously suffered from rheumatism or are of the "rheumatic type," have been pointed out by many observers.

It may be taken as proved (see the article on Bacteriology in the ANNALS OF SURGERY for August, 1886, by Dr. Van Arsdale) that gonorrhœa has for its cause the gonococcus as demonstrated by Neisser, Bumm and others. It has also been noticed that occasionally a patient who had recovered for some time from an attack of gonorrhœa, was liable to fresh outbreaks of urethritis (without fresh exposure) following some abuse of stimulants, etc. We must suspect in these

cases that the gonococci have remained dormant in the urethra for a considerable time, and if this be the fact, it may serve to elucidate those cases in which urethral arthritis follows catheterism and in which there is no evidence of recent gonorrhœa. At the same time the nerve-reflex theory advanced by Dr. Ord and others cannot be entirely ignored. Obstinate sciatica and lumbar neuralgia are occasional sequences of gonorrhœa, and these symptoms would certainly fit in well with the reflex theory. One further difficulty remains in the asserted connection between a tendency to gout and the liability to arthritis after gonorrhœa. Although many obscure points as to urethral arthritris must remain as yet undecided, yet the evidence of its microbic nature, as shown in isolated cases by Smirnoff, Petrone, Hemmerer and Afanasieff is becoming strong and may ultimately assist us in the treatment of this most troublesome disease.—*Vratch*—see *Lancet* of August 28, 1886.

II. **The Treatment of Syphilis by Subcutaneous Injections of Mercury.** By J. ASHLEY BLOXAM. Mr. Bloxam states that during the last two years upwards of fifteen hundred cases have been healed at the Lock Hospital by the intra-muscular injection of corrosive sublimate. One-third of a grain of the drug in aqueous solution is injected into the gluteus maximus (or sometimes the trapezius) and the proceeding is repeated once a week, in all from eight to twelve grains of the perchloride being used for each case. It is obvious that if this small quantity suffices for the treatment of secondary syphilis protracted during some twelve months, the amount usually given by other methods is considerably greater than is required, granting that the drug is twice as potent when given hypodermically as in the same dose by the mouth. Mr. Bloxam generally orders quinine whilst the patient is undergoing the injection treatment—which he asserts never produces ptyalism or gastric disturbance.

We must own to a belief that this method of healing syphilis will not come into general use, especially since various previous observers having given it a careful trial have subsequently abandoned it.—*Lancet*, August 21, 1886.

J. HUTCHINSON, JR. (London).

III. **Hereditary Syphilis in a Man Æt. 30.** A. FOURNIER (Paris). Prof. A. Fournier describes the case of a man æt. 30, with undoubted manifestations of hereditary syphilis and believes that there has been no authenticated case occurring at a later age. The patient presented himself with patches of ulceration on the penis. They involved the fold between the glans and prepuce, also the meatus. They were three or four millimetres in width, with a yellow putrid cavity, surrounded by a dark areola and some induration. They had all the appearance of broken down gummata. The glands in the groin were not affected.

He at once declared the case to be one of tertiary syphilis much to the patient's surprise who declared this to be his first venereal mishap, and it was only on cross-examination that he obtained the following conclusive facts: (1) The patient had been slightly deaf of both ears since early infancy, but had never had any discharge from them. (2). At 14 he had suffered from double keratitis with total temporary blindness. There were no appreciable traces left to show this. (3). In childhood there had been some serious lesion of one knee, leaving deformity and much scarring. The patient had suspected syphilis in his parents. The mother's medical attendant, who was consulted, stated that she had been infected with syphilis by her husband during her pregnancy, that the patient himself was treated for syphilis in his early infancy and had even communicated it to his wet-nurse.—*Gaz. hebd. de Med. et de Chir.* Oct. 29.

L. MARK (London).